SILNE-R
Enhancing the Effectiveness of Programs and Strategies to Prevent Youth Smoking: A Comparative Realist Evaluation of Seven European Cities

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Recommendations to prevent youth smoking in Belgium (national, local and school)

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Work Package 3 (WP3)
DELIVERABLE REPORT D3.2
APPENDIX K

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Fine-grained (evidence-based, context specific) recommendations at national, local and school levels to prevent youth smoking in Belgium

Belgium: Context

Belgium, the capital of which is Brussels, has a population of 11.5 million. Namur has a population of 110,000 and a physical area of 176 km^2. Belgium had a national tobacco score of 47 in 2013, and 49 in 2016. In Namur, weekly smoking prevalence in SILNE schools in 2013 was 18% and in SILNE-R schools in 2016, it had decreased to 15.6%.

Data sources for findings and recommendations in this report

The fine-grained policy recommendations to prevent youth smoking in Belgium that are contained in this report are based on findings and recommendations from many quantitative and qualitative data sources collected for the SILNE-R project (2015-2018). The fine-grained recommendations for Belgium in this report should be read in conjunction with the reports containing cross-national, national, local, and school-level findings and recommendations (D3.2 Appendices A, B, C and D).

Overseen by WP8, surveys of more than 13,000 school students in 7 cities were carried out (2016/17) to examine student health, social networks, smoking (prevalence, access to cigarettes, attitudes to smoking, parental smoking, location of smoking, smoking in the home, e-cigarettes, *etc.*), perceptions of school tobacco policies, *etc.*. The general participation rate for student surveys was 89.6 % (all countries). In Belgium, 1949 students participated (96.53% participation rate).

From late 2016-2017, overseen by WP9, 56 single-sex focus group interviews took place, 8 in each of the 7 cities, involving 319 participants. The focus groups paid particular regard to school smoke-free policies and age-of-sale laws. Participants were recruited by teachers, who identified students they believed to be smokers or at risk of becoming smokers. Half the focus groups were conducted with girls and half with

boys. Overall, 168 girls and 151 boys participated, with 3-9 participants per group. Half of all groups were conducted with students attending schools that served a predominantly high socioeconomic status (SES) population, and half in schools serving a low SES population. Adolescents were aged 14-19 (average age of participants was 15.2 years) with most focus groups having participants under the legal age limit of that country, with the exception of seven focus groups in Belgium (age range of 14-18). In Namur, 4 focus groups were held with boys and 4 with girls in 2 participating schools.

Staff questionnaires regarding school characteristics, school tobacco policies, health promotion and prevention, *etc.* were also completed for WP8 and interview data with staff was collected for WP7. Consultations and focus group interviews (initial and follow-up) were held with policymakers and stakeholders from the 7 SILNE-R countries and also from other EU and non-EU countries, overseen by WP5 at the national level, and by WP6 at the local level.

Data relating to enforcement and implementation costs of certain tobacco control measures (ban on sale to minors; point-of-sale advertising; ban on smoking in public places) was overseen by WP10. In some cases, school staff were interviewed regarding the cost of school bans and educational programmes for WP10 (cost questionnaires/interviews).

National-level findings and recommendations to prevent adolescent smoking

Belgium, like the Netherlands, is a moderately progressive country, having tobacco control policies that are not particularly strong but that have advanced in recent years. WP5's[1] analysis of policy monopolies of pro and anti-tobacco interest groups across six European SILNE-R countries found that one of the main factors influencing variation in tobacco control policies across European countries is the relative policy dominance of pro and anti-tobacco control interest groups. WP5 examined whether there are patterns and similarities with regard to framing of tobacco and institutional arrangements across countries that have a relative dominance by either one of the two groups. In doing so, they conducted 32 semi-structured interviews with relevant

stakeholders in Belgium, Finland, Germany, Ireland, Italy, and the Netherlands. They found that, in countries where health Non-Governmental Organizations (NGOs) have a policy dominance in tobacco control, NGO communities are well developed and have tight links to government while the industry is largely economically absent. In addition, the health ministry plays a central role in the policymaking process, FCTC Article 5.3. is strictly interpreted and the framing of tobacco focuses on the health aspects of smoking. In contrast, in countries where the tobacco industry and associated businesses have a policy dominance, the industry is more strongly embedded in the domestic economy while NGO communities are weak or absent in the field of tobacco control. In these countries, the health ministry plays a subordinate role in the policymaking process, FCTC's article 5.3. is only interpreted in terms of transparency and tobacco is framed as a private problem. They concluded that the way tobacco is framed in a country and the way institutions are arranged correspond to the policy monopoly in place, with strong similarities across countries with the same policy monopoly.

Despite an active community of health NGOs in Belgium, the political agenda of the current ruling party often objects to the introduction of strict tobacco control regulations. Since tobacco control has not been a priority, the response to policymaking has been stagnant and uncoordinated. Consideration is being given to plain packaging and legislation banning smoking in vehicles with children.

Namur relevant national-level recommendations

1. Adolescent smoking remains a problem

The problem of adolescent smoking has not disappeared. SILNE-R WP8[2] (2016-2017) data for Namur shows adolescent ever-tried smoking at 47.24%, weekly smoking at 18.15%, and ever users of e-cigarettes at 46.57%. Tobacco causes unique and disastrous consequences for adolescents and tobacco control must be kept at the top of the policy agenda in all countries.

Recommendations:

- **There is no safe level of smoking and smoking prevalence among adolescents continues to be a problem. Tobacco control is in competition**

with, and in danger of being swamped by, priorities shifting to other adolescent health problems. We recommend keeping tobacco at the top of policy agendas, with constant reminders of the death and disability uniquely caused by smoking.

2. Cognisance needs to be taken of policy change processes

SILNE-R data[3] show the importance of policy change processes in shaping tobacco control policies within individual countries. For the most effective tobacco control policy enactment, cognisance must be taken of these processes by tobacco control advocates and stakeholders.

The strength of the dominant frame (health side versus tobacco industry) influences the policy environment and the receptiveness to change within the policy system[4]. For countries where the health side of the framework is dominant, there is an intersectoral approach to population health that engages with multiple sectors and actors[5]. Specifically, within this frame, the Ministry of Health is responsible for creating and introducing new policies. There is co-ordination between government health departments and health advocacy organisations to drive and develop policies. The health frame is dominant in Belgium, and there are active health advocacy organisations working within the country. However, the political agendas of the ruling political parties are unreceptive to interests of tobacco control advocates and such forces reduce the advancement of stricter policies. This may be explained by liberal right-wing parties being in power. For example, in Belgium the Minister for Health did not consult the ministry for health when constructing the previous tobacco act.

In countries where the tobacco industry side of the framework dominates, other government ministries (outside of health ministries) often have responsibility for tobacco policy and health advocacy organisations within these countries may not be active or may lack the leadership, strategy and resources to achieve policy goals. While Belgium does suffer from these problems, it still has some work do to in tobacco control to reach the standard of the most progressive countries. For example, the point-of-sale display ban has been put on the political agenda but needs to be progressed. There are discussions about plain packaging and smoking cars with children but it remains uncertain whether these proposals will translate into policy during the current legislative period (2018).

Recommendations:

- **It is recommended that, when developing tobacco control policy and advocating in Belgium, cognisance is always taken of the particularised complexity of the national policy context and that up-to-date data are maintained regarding dominant frames that shape tobacco control within each country.**
- **We recommend that monitoring and development of tobacco control policy and legislation in individual countries takes into account the current tobacco control landscape in Belgium as well as the country-specific beliefs and values that underpin policy, legislation and practice. Politically, for example, a liberal-conservative ruling party ideology hampers progressive tobacco control efforts in Belgium and this forms part of Belgium's national dominant governmental political frame. However, other dominant frames (civil/ institutional/ social) also contribute to the particularised complexity that is the policy context in Belgium, and further data are required in order to understand these, and how they intersect, better.**
- **Education in the complexities of policy change processes is recommended for tobacco control advocates, NGOs and health experts in Belgium whose professional substantive areas of expertise can not be expected to include policy change processes and policy paradigms. This is particularly important in Belgium where health NGOs are active but likely hindered by the implicit force of a taken for-granted *tobacco control policy paradigm*.**
- **Further research is required to "fill out" the understandings gained by WP4 and WP5 regarding policy monopolies in SILNE-R countries and to keep them up-to-date. Such research would develop the concept of a *tobacco control policy paradigm* and explicate its particularised operation across Europe countries and (regional and other - demographic *etc.*) contexts.**

3. Dominant negative frames must be exposed and, where appropriate, challenged and changed

Dominant values and beliefs that underpin tobacco control policy and that negate

tobacco control progress are often under-exposed, taken-for-granted, and unchallenged within individual countries. These dominant frames should be exposed and challenged, and, where appropriate, efforts directed at changing frames to ones supportive of progressive tobacco control policy environments. This latter could be done through the development of intersubjective discourses (*e.g.*, focussed on evidence bases, health, child frame), and the promotion of robust health advocacy organisations, whose role is central to progressive tobacco control environments.

In Belgium, there is subsystem dominance of the health network but receptiveness of the government seems limited.

- **In terms of a dominant governmental frame in Belgium: Further develop public discourses that highlight tobacco harms, are protective of citizens, and emphasise child health.**
- **In terms of civil and business institutions: Further develop strong health NGO advocacy groups. Make networks and follow example from countries where health advocacy groups are strong (*e.g.*, Finland, Ireland). This latter may be particularly useful in Belgium where, with support and intervention, strong health advocacy groups may be abe to increase their impact on tobacco control efforts,**
- **We recommend an audit of current tobacco control-related organisations, and interventions (resources, development) in order to be able to support them individually. We further recommend that international tobacco control organisations (ENSP/ SFP/ FCA) establish sub-groups charged with advocating for national-level transferability of knowledge that is based on the complex policy monopoly environment within which each country operates.**
- **Encourage health advocacy groups in Belgium to forge close co-operation with government while developing aligned policy stances between tobacco control and government views. This can be aided by dissemination of tobacco control research, to the public and the government, showing health benefits of highly cost-effective tobacco prevention interventions; by bringing novel practical interventions to general notice; and by showing the popularity with the general population (electorate) of good tobacco control legislation. NGOs should also be free and willing to support political champions of Tobacco Prevention public health policies.**

NGOs should align their demands, for protection of children from the harms of smoking and of second-hand smoke, with the public health efforts of Health Ministries. By insisting that governments are complying with FCTC Article 5.3, NGOs can help to protect tobacco control political actors from Tobacco Industry influence. They can also dampen down, reduce and help to eliminate the influence of pro-tobacco institutions such as retailers by supporting and encouraging the banning of payment for tobacco display and the banning of sponsorship by pro-tobacco institutions. These efforts can be reinforced by extending the negative images of the tobacco industry established in progressive tobacco control cultures to ones with weaker cultures. This can be facilitated by fostering strengthened links between national tobacco prevention coalitions which collaborate to identify successful, transferable, context-specific strategies.

- **In terms of governmental institutions: Create clear strong guidelines regarding interpretation and implementation of FCTC Article 5.3. Advocate for Ministry of Health capacity in tobacco control, ensuring adequate numbers of personnel with specific focus on tobacco control whose work is not diluted by other prevention areas.**
- **Overall, in Belgium strengthen health monopolies and weaken tobacco industry monopolies.**
- **Pay attention to moments of potential change when stable policy-making processes are disrupted by moments of crisis. At these times, policy change may be more likely to occur. Note the work on Punctuated Equilibrium Theory Framework detailed in Appendix A.**

4. Tobacco control efforts showing success but more needed for health and equality

Current tobacco control policies are taking effect, evident in reduced adolescent smoking prevalence in Belgium but gains are not homogeneous, with tobacco-related health inequalities evident across population sub-groups. Further observations and recommendations on smoking prevalence and trends, including on social inequalities, SES, gender, social networks, and migrant families are to be found in D3.2 Appendix A. This is not a time for complacency but for continued, expanded and translated and

transferred tobacco control efforts.

Recommendations:

- **In Belgium, a moderately progressive tobacco control environment, two broad approaches are required.**
  - **1. Continue with existing policies and interventions that are good, ensuring strict enforcement.**
  - **2. Expand tobacco control efforts by adding new interventions where they are lacking (see D3.2 Appendixes A, B, C, D for further suggestions and recommendations).**
- **Belgium has work to do in tobacco control and we recommend an additional two approaches in addition to the two foregoing approaches. These are:**
  - **3. Require compliance with extant treaty and other obligations. At a minimum, all reluctant countries must be required to fulfill their obligations to children under the binding Framework Convention on Tobacco Control Treaty (FCTC) as well as EU commitments and duties integral to the full implementation of the Tobacco Products Directive (TPD), and**
  - **4. Support successful transfer of good policy from countries with more progressive tobacco control environments. This would involve translating various measures, practices, and value systems into local contexts in usable ways. At a simple level, this would mean raising the National Minimum Age of Sale of cigarettes in Belgium to 18 years, bringing it into line with other countries. At a more complex level, and more difficult to achieve, it would mean translating the value and belief systems - and dominant discourses - underpinning dominant governmental frames, civil and business institutions, and Ministries for Health in countries with more progressive tobacco control environments, for use in Belgium with its less progressive tobacco control environment. In practice, this would require a number of steps: the evaluation of current beliefs and values regarding health priorities vs profit priorities in the latter countries; the re-prioritisation (through, for example, advocacy, branding, and legislation) of beliefs and values to**

support the prioritisation of health and health advocacy organisations; and on-going excavation, monitoring and evaluation of dominant belief and value systems - and dominant discourses - to support continued emphasis on health, and the right to health environments, and consequently, as demonstrated in SILNE-R, lower youth smoking prevalence.

5. Specific measures required to increase tobacco control progressiveness

Progressive tobacco control policy environments are characterised by systematic transposition of, strong compliance with, and strict enforcement of the Framework Convention on Tobacco Control (FCTC) treaty; the "Big Six" MPOWER[6] policies; the EU Tax Directive and the EU Tobacco Products Directive (TPD). SILNE-R cities in countries that have lower youth smoking prevalence are characterised by such progressive tobacco control policies. We make a strong recommendation for firming up these policies at national level, especially in countries found to have moderately progressive tobacco control policies such as Belgium.

Recommendations:

- **We recommend a comprehensive rolling-out of demonstrated effective policy (e.g., FCTC, MPOWER) bringing Belgium with its more moderate tobacco control policies into line with countries with the most progressive ones.**

Specifically, this means:

- **More rigorous implementation, enforcement and oversight of FCTC policies recommendations.**
- **Better enforcement of smoke-free legislation.**
- **Consider developing and implementing an 'endgame' plan in the Netherlands. Countries that have done this already have translated the endgame aspiration into policy.**

6. Access: enforcement and other measures needed

National Minimum Age of Sale Laws (NMASLs) are designed to prevent young people from accessing cigarettes, with the aim of reducing youth smoking uptake and

prevalence. Nevertheless participants across SILNE-R cities including Namur, accessed cigarettes with ease, using a variety of methods to obtain cigarettes from: ‘legitimate’ retailers or vending machines; people above the legal age of purchase; friends; ‘proxies’ (known or stranger adults who purchased cigarettes on their behalf); stealing from family members; buying from other young people; and purchasing cigarettes abroad. Methods to access cigarettes differ across cities, reflecting variation in the implementation or enforcement of NMASLs at a national or local level.

WP9 conducted focus group interviews with 319 young people from 17 schools, with similar numbers drawn from high and low socio-economic status populations and from girls and boys. Young people's perceptions and experiences of accessing cigarettes were explored. Access across the 7 cities was largely in contravention of national minimum age of sale laws (NMASLs). In Belgium, the national minimum age of sale is 16 years. Belgium is legally unusual insofar as its NMASL prohibits the sale of cigarettes to young people under the age of 16 (rather than 18, as in most other EU member states).

- Participants reported that minors could buy cigarettes from legitimate retailers, particularly from ‘night shops’ (largely staffed/owned by members of ethnic minority communities e.g. Belgian Pakistanis).
- Participants widely report being able to buy individual cigarettes from the above retailers.
- Belgian participants did not discuss vending machines.
- Some participants reported using acquaintance proxies, who were easily accessed within the school (the Belgian approach of ‘holding students back’ to repeat an academic year routinely put younger students in direct contact with older students (*i.e.*, 16 +)).
- No Belgian participant made mention of vending machines.

Policy recommendations are based on WP9[7] and other SILNE-R findings.

Recommendations:

- **Meaningful enforcement is the most important measure. Enforce national minimum age of sale laws. Raise minimum age of sale to 18 years in Belgium in line with all other SILNE-R countries. This would also have the indirect positive effect of improving the tobacco control environment**

in the Netherlands, where the NMAS is 18 years, resulting in some 16 and 17 year old adolescents to cross the border to purchase cigarettes in Belgium where it is legal for them to do so. Consider raising NMASL to 21 years.

- **Remove all vending machines as they are not, and cannot be, adequately policed.**
- **Strengthen supply side restrictions. Consider the introduction of a licencing levy, or a penalty to discourage smaller retailers from supplying cigarettes to underage purchasers.**
- **Take action on proxies via awareness raising.**
- **Policy-makers should consider how 'holding students back' (*i.e.*, requiring students to repeat an academic year) can change peer group configuration and dynamics – particularly with regard to accessing cigarettes - and shape their interventions accordingly.**
- **A trans-national European approach - the fluid borders of Europe and the mobility of its citizens - means that successful policy-making should be seen as a supra-national/international endeavour.**
- **Further context-specific recommendations are detailed in Appendix D.**

7. Costs and cost effectiveness of various TC policies in Belgium

As regards the current landscape of tobacco control policies and their costs in 7 European cities / countries, the findings of WP10[8] provided a snapshot of costs for the implementation of various policies to prevent adolescent smoking. In Namur/Belgium:

- A year of implementation of non-school bans (bans on smoking in public places, bans on sales to minors, bans on advertising at point-of-sale) cost €0.17 per person covered (PPP).
- A year of implementation of school bans cost, in mean, €16.15 per student covered (PPP), if considering a conservative perspective. Considering a realistic perspective, the implementation of this ban cost €0.21 per student.
- The implementation of a school smoking prevention programme cost, in mean, €2.38 per student covered (PPP).
- Long-term effectiveness estimates ranged from 57,700 to 2,887,000 healthy years gained after the implementation of a strategy with a short-term

effectiveness of 1 to 50% relative reduction of smoking prevalence, respectively.

- For these cost and effectiveness estimates, the implementation of non-school bans, school bans (realistic and conservative perspectives), and school programmes was highly cost effective (according to the WHO threshold of 1 times the GDP per capita) for the reduction of at least 1% of the prevalence of smoking among adolescents.

Recommendations:

- **Data on cost and cost effectiveness are scarce but it is clear from WP10 that school tobacco control policies (STPs) are highly cost-effective.**
- **To maximise the potential for use of financial data to support a demand for appropriate STPs, it is important that cost and cost-effectiveness data collection be made a component of STP monitoring and be available to support policy makers.**
- **It is important that the cost effectiveness of smoke-free laws is emphasised and kept prominent when public health, and particularly disease prevention, is being considered.**
- **Cost-effectiveness is a valuable tool when advising policy-makers and may be particularly important when tobacco control policies are in competition with, and possibly getting a lower priority than, other prevention areas for resources and public (electoral) support.**
- **Cost-effectiveness should be included in intersubjective discourses being developed by tobacco control advocates.**
- **Collection of cost data for use in cost-effectiveness analysis should be part of monitoring of smoke-free laws.**

Local-level findings and recommendations to prevent adolescent smoking

WP3 synthesised and translated evidence from SILNE-R WP4-10 in order to make local-level recommendations for the prevention of youth smoking in Belgium. Using the prism of WP4 policy models and briefs, and drawing on WP6's qualitative assessment of expert interviews (n=56) with European decision makers and

stakeholders, and a consultation group, we make some observations. These observations and resulting recommendations are described in detail in D3.2 Appendix C.

Local context

Separate from a national policy and legislative context, schools exist within local contexts that must be taken into account in order to reduce and prevent adolescent smoking. Local primary prevention in schools in Belgium must be framed with adequate national tobacco control policies, such as effective tobacco taxation and advertising bans, but features of the local context may support or hinder reductions in smoking prevalence among young people. In particular, local factors can create environments that, rather than discouraging young people from smoking, serve to facilitate youth tobacco use. This occurs despite national legislative frameworks, as a consequence of poor local enforcement, or lack of specific policy or legislation at the local level.

A critical realist qualitative study of the implementation of smoking bans at the local level of 7 SILNE-R cities based on semi-structured expert interviews (n=56) with local decision makers[9] showed that existing implementation processes at the local level in Belgium may be categorised as "lower saturated" rather than "progressive-hungry", "moderate-rational", or "upper-saturated". These types differ mainly in regard to their engagement in enhancing smoke-free environments as well as along their level of perceived tobacco de-normalisation and public smoking visibility. Smoke-free environments are adopted at national levels, but differently implemented at local levels due to varying contextual factors, such as the level of collaboration, enforcement strategies, and national policy environments. Different legislative and administrative conditions lead to four implementation types and binary mechanisms of "expansion" and "closure". Major mechanisms to expand future smoke-free regulations were found to be intersubjective arguments, such as scientific evidence, public support, and the child frame. However, counter-mechanisms of closure, like data on declining prevalence or "new trends in addiction", can result in low priorities. Four smoke-free trans-local types and two mechanisms of "expansion" vs. "closure" were identified. To support smoke-free expansion at the local level, a number of approaches are recommended. In order to be able to enhance existing smoke-free

areas at the local level in the EU, local levels must be assisted by national levels, better use must be made of intersubjective arguments, particularly around the "child frame", and ongoing monitoring and evaluation must be ensured. Therefore, they identified the following approaches to improve the implementation of smoke-free bans at the local level: 1. Local TCPs must be framed, as in Ireland and Finland, within adequate and ambitious national policy environments, such as effective tobacco taxation, comprehensive smoke-free laws, banned vending machines, plain packs, point-of-sale and advertising bans. 2. Smoke-free laws need to be adapted and modernized specifically for outdoor places (*e.g.*, playgrounds) and private contexts (*e.g.*, cars) that are frequented by children. 3. Regular and active smoke-free-monitoring enhances effective long-term enforcement of smoke-free environments. An implementation plan (based on Ireland and Finland) including tobacco-focussed long-term monitoring at local levels, and reported documentation of developments is needed. Regional differences should be considered here, since financial and personnel resources are often unequally distributed across different administrative districts.

Barriers at the local level

Barriers identified across the 7 cities to successful local-level implementation of tobacco control activities to prevent youth smoking are: lack of a unified structure that deals with implementation, monitoring and enforcement of national-level policy and legislation; lack of an 'implementation plan' or strategy or endgame vision for prevention of youth smoking; lack of resources for tobacco control at local level; uneven efforts regarding denormalisation and specifically, advertising bans; inadequate expansion of smoke-free spaces, especially those where children may be (all indoor and outdoor areas in schools, health facilities, crèches, recreational facilities, sports stadia); and need for increased efforts for population sub-groups suffering specific disadvantage regarding smoking prevalence (low SES groups; some school types and tracks).

Suggested solutions at the local level

Suggested solutions to mitigate these barriers at the local level include tobacco taxation, institutional structures, expansion of smoke-free spaces, and community involvement. The use of intersubjective discourses - especially regarding evidence bases and child frames - is necessary and health advocates must employ intersubjectivity as a way of building support and achieving policy consensus around

smoke-free (and other policy) initiatives at the local level as much as at (inter-)national and school levels. These suggestions and derived recommendations are detailed in D3.2 Appendix C.

Namur relevant local-level recommendations

A summary of Namur relevant local-level recommendations to support the prevention of youth smoking is listed here.

Recommendations:

- **Emphasise the continuing need to improve national-level tobacco control policies to avoid the emergence of complacency and achieve the tobacco control 'endgame'.**
- **Institute a national-level office of an ombudsman/woman charged with national, local and school-level oversight of tobacco control and particularly the prevention of youth smoking.**
- **Prioritise low SES groups as they have higher smoking prevalence than everyone else and pool limited resources for socially disadvantaged contexts.**
- **Expand child-related smoke-free contexts, such as cars carrying minors and certain smoke-free outdoor areas (e.g., playgrounds, public parks).**
- **Consider localised community-group interventions for tobacco control, e.g. in the arts arena.**
- **Use intersubjective discourses at the local level and ensure that there is continuing health education concerning tobacco and nicotine addiction.**

School-level findings and recommendations to prevent adolescent smoking

School-level findings and recommendations to prevent adolescent smoking focus on smoke-free schools, school tobacco policies (STPs), and tobacco-related health education.

Smoke-free schools

In Namur, a comprehensive school smoking ban exists, but problems continue with

students smoking within school buildings and on the school premises. Educators play a significant role in enforcing school rules prohibiting students smoking in schools. In Namur, the effects of smoking visibility were observed to promote smoking through several mechanisms: peer effect; social pressure; and "wrong" tobacco norms internalisation.

Recommendations:

Strong efforts to make schools smoke-free, both inside and outside the school premises, should have a positive effect on prevalence. Comprehensive bans, strictly enforced, are recommended.

Implementation of school smoking ban in Namur.

In its report to WP3[10], WP7 provided a brief overview of the implementation of a school smoking ban in each of the 7 SILNE-R countries. Its report was based on topics that were discussed in the school staff interviews and did not aim to provide a comprehensive understanding on policies in each country/schools. In Belgium, the public places smoking ban was implemented in early 2000, which also had impact on smoking bans at schools. All together, even though smoking was not considered as the main problem in schools, problems, e.g. students smoking outside school premises (and in toilets), were discussed. Also, in many schools, there was an official/unofficial smoking place appointed for staff. One school provided a smoking room for staff inside a school building in order to prevent students from seeing staff smoking. Educators had a significant role in enforcing school rules in general, and collaborating with students. Educators also had the main responsibility in smoking ban enforcement (e.g., monitoring). However, all staff members' commitment to enforcement was considered necessary.

Adolescent adherence to smoke-free school policies

Focus group research carried out with 319 students in 17 schools across 7 cities to explore adolescents' reports of variations in adherence to smoke-free schools policies was analysed by WP9 and synthesised for WP3[11]. Participants were recruited from two schools (one low SES and one high SES) in Namur.

- Students in the High SES school reported low on-site smoking, but suggested that overt off-site smoking was relatively common.
- Students in the Low SES School reported fairly high levels of on-site

smoking, which may have been facilitated by a failure on the part of teachers to enforce smoke-free school policies.

Recommendations:

- **School policies on smoke-free schools need to be clear about what is expected of students, and about the extent of smoke-free areas on school campuses (school boundaries) as well as about off-site smoking at the periphery of school campuses.**
- **Smoke-free policies should be comprehensively communicated using multiple modalities (written / signage / talks etc.) and communicated over time so that students are clear about actual policies rather than reported ones.**
- **Enforcement of smoke-free policies should be consistent and meaningful (*e.g.*, include surveillance of the whole school site' "buy-in" by all teachers regarding enforcement of smoke-free school policy).**
- **Consideration should be given to teacher and student perceptions of the school jurisdiction (*i.e.*, the space and time over which school rules are enforceable) and how they have an impact on willingness to enforce/ observe a school-site peripheral smoking ban; and on teachers' "right" to influence student behaviours both on and off the school site. Teacher and student "buy-in" is essential to successful implementation of smoke-free school policies. Such consideration could occur in the context of whole-school policy development that seeks to include all stakeholders in committing to policy.**

School tobacco policies

Tobacco control policies at schools (STPs) were examined by WP8 and each school given a STP score [12]. The STP score comprises three dimensions, namely comprehensiveness (who, where and when the policy applies to, whether they have smoking rooms installed and whether students perceive that there is a policy), enforcement (whether students perceive the policy as strict and the different types of consequences applied if a student is caught smoking) and communication (whether the policy is formal and how it is communicated to others). Each dimension ranges from 0 to 10 and the STP score is an average of all three dimensions. Overall, there was a significant improvement in the implementation of STPs in Namur between

2013 and 2016. In that time, there was a significant increase between 2013 and 2016 in the comprehensiveness of the STP (7.5 to 8.6, $p<.05$) and in its communication (4.8 to 6.6, $p<.05$). There was no significant change in the enforcement of the policy (2.5 to 2.6). Overall the total score of the policy increased from 4.9 to 5.9 ($p<.05$).

Tobacco-related health education

From an analysis of interview data with school staff members, WP7 provided for WP3 an account of the current landscape of tobacco-related health education within the seven SILNE-R cities[13]. In Belgium, education on tobacco and smoking prevention is integrated within the curriculum of Science, Biology, and Religion. Provision is not systematically included, however, but depends on factors such as school type, curriculum content, student age, and student track. Core elements of tobacco-related health education include awareness raising of long-term consequences of smoking, passive smoking, and addiction. Teaching methods were reported to vary, depending on individual teachers' interest in the topic. Time allocation also affected methodology.

As in most countries, decreases in smoking prevalence have led to tobacco-related health education receiving lower priority. Staff reported that motivation, initiatives for developing programmes, investment of effort and resources were all lacking as a result of the low priority being placed on the need for smoking prevention. Furthermore, a *status quo* was identified whereby schools were doing the prescribed minimum in education about tobacco, with no need for additional efforts. The effectiveness of dominant teaching styles and modes of delivery of tobacco-related health education is not assessed but staff considered them minimally effective.

Recommendations:

- **A decrease in smoking prevalence among adolescents everywhere has led to Tobacco Control being a victim of its own success in schools, and at risk of being overshadowed by other health issues which are seen as more acute and "growing" problems. Everywhere, educators report that the focus has shifted from tobacco and onto other areas of health concern. It is very important that those students who do smoke or who are at risk of smoking are not left behind at this time, by being ignored by the shifting**

emphasis to other health harms. This is particularly the case as students at risk from smoking are more likely to be in low SES groups and, therefore, at greater risk of multiple disadvantage.

- **A re-invigorated approach for staff teaching tobacco-related health education is required, suggesting the need for revised tobacco-related health education curricula to reflect decreasing prevalence among adolescent smokers with an emphasis on resistant adolescent quitters and adolescents at risk of starting to smoke; changing trends in tobacco use and new tobacco products; and more up-to-date teaching methodologies and pedagogical strategies.**

Teaching methods, school culture and support for quitters

One school in Namur, reported as an exception, that had developed a tobacco-related health education programme was described as a "human school". This school adopted a more collaborative approach, involving communication and partnership with parents and local stakeholders. The school culture had an impact on practices in the school. For example, it offered targeted education during detention for students who had broken the smoking ban, and emphasised group dynamics, peer pressure, decision-making, and building self-confidence.

Recommendations:

- **Develop a detailed profile of "good practice" schools, providing guidance on and exemplars of how to support students in quitting smoking or in not starting.**

Collaborations with local partners

In terms of collaboration with local partners, no ongoing extra activities, theme days or campaigns on smoking prevention were reported to be organised or planned. Individual teachers can, however, invite experts from local NGOs to give stand-alone lessons for students. Again, however, these tend to be *ad hoc* activities and lack a long-term strategy.

Recommendations:

- **Compile a database of local partners, NGOs, etc. and encourage systematic collaborations between schools and local partners.**

Materials and resources

Schools reported that they do not have resources for developing prevention programmes of tobacco-related health education. Interviewees believed that a comprehensive health promotion strategy is required and that development of resources should be carried out by educational authorities.

Recommendations:

- **Develop a set of lesson plans, materials and resources suitable for use in tobacco-related health education lessons, modules and programmes. These could be made available in a centralised online database or website, freely available to teachers.**

Support for addicted students

Smoking cessation support for addicted students was not seen as the responsibility of the school. Advice regarding seeking help from local NGOs is offered.

Endnotes

[1] WP5 (UNIMASS), D5.3, Article 3: Who calls the shots in tobacco control policy? policy monopolies of pro and anti-tobacco interest groups across six European countries. Paper submitted to 'Social Science and Medicine'. Final SILNE-R Report, September 2018.

[2] WP8 (UCL). D8.2. Report on cross-national differences. Final SILNE-R report, 2017.

WP8 (UCL). D8.3, Appendix 9.b. paper 2, Vincent Lorant, Adeline Gerard, Nora Melard, Pierre-Oliver Robert, [SILNE-R- Coauthors], Anton Kunst. Trends in adolescents smoking in 6 countries. Final SILNE-R report, September 2018.

[3] WP5 (UNIMASS). Deliverable D5.2. National-level analysis of the implementation of tobacco control strategies. (2016).

WP5 (UNIMASS). Deliverable D5.3. Final report on integrated evidence. Final SILNE-R report. September 2018.

[4] The full findings from WP5 are to be found in D5.3.

[5] WP5 (UNIMASS). Deliverable D5.2. National-level analysis of the implementation of tobacco control strategies. (2016).

[6] MPOWER: Monitor tobacco use and prevention policies, • Protect people from tobacco smoke, • Offer help to quit tobacco use, • Warn about the dangers of tobacco, • Enforce bans on tobacco advertising, promotion and sponsorship, and • Raise taxes on tobacco.

[7] WP9 (UEDIN), 2018. Adolescent Tobacco Control Policy Recommendations: WP9 Recommendations to WP3. Internal SILNE-R report from WP9 to WP3, 26 March 2018.

[8] WP10 (NSPH) Policy Recommendations Template for WPs 8 & 10, Feeding back findings to WP3. Internal SILNE-R report from WP10 to WP3, 3 April 2018.

[9] WP6 (MLU). Appendix 3 Martin Mlinarić, Laura Hoffmann, SILNE-R study group, Matthias Richter, Enhancing smoke-free environments at the local level: a comparative realist study and qualitative type construction across 7 European cities. SILNE-R Draft paper, September 2018, Final SILNE-R report and Presentation to SILNE-R: Sixth Consortium Meeting, Madrid, June 12-13, 2018, Hospital Clínico Universitario San Carlos.

[10] WP7 (UTA). Smoking Ban. Final report on school smoking ban implementation in seven European countries. Internal SILNE-R report from WP7 to WP3, May 2018.

[11] WP9 (UEDIN), 2018. Adolescent Tobacco Control Policy Recommendations: WP9 Recommendations to WP3. Internal SILNE-R report from WP9 to WP3, 26 March 2018.

[12] WP8 (UCL). The current landscape of tobacco control policies within seven European countries / cities. Internal SILNE-R report from WP8 to WP3, April 2018. WP8 (UCL). D8.3. Report with general overview. Final SILNE-R report, September 2018.
WP8 (UCL). D8.3, Appendix 9.a. paper 1, Nora Mélard, Adeline Grard, Pierre-Olivier Robert, Mirte Kuipers, Michael Schreuders, Teresa Leão, Laura Hoffmann, Matthias Richter, Arja Rimpela, Anton Kunst and Vincent Lorant. School tobacco policies and adolescent smoking in 6 European countries. Final SILNE-R report, September 2018.

[13] WP7 (UTA). Education. Final report on tobacco related health education. Internal SILNE-R report from WP7 to WP3, May 2018.